

COOPERATION OF HOSPITALS IN CANADA: REGIONALIZATION, MERGERS, AND SHARED SERVICES*

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ALTHOUGH Canada is politically distinct from the United States, the problems in the two countries are similar. Canada is divided into 10 provinces and two federally administered northern territories, the Northwest Territories and the Yukon. Responsibilities for health, education, and welfare are enshrined in the Canadian constitution as the responsibility of the provinces. Each province has its own provincial legislative assembly, based largely on the British system of parliamentary government. The federal government is also based on the British system, and the Queen of England is the titular head of state. The federal government, in its electoral procedures and parliamentary exercise of authority, also resembles the British system closely. However, despite constitutional responsibility of the provinces for health, the federal government has assumed a major role in the system of delivering health care, through financial participation with the provinces in the administration of a national hospital and health insurance scheme. This heavy involvement of the federal government in an area technically sacrosanct to the provinces arose from a general public demand initially for hospital insurance and subsequently for medical care insurance. The general acceptance of the federal role is because of its function as principal collector of income and excise taxes on behalf of both the federal and provincial governments. To some extent, at least, this has permitted the federal government to spread funds more uniformly throughout the country, so that less economically favored provinces benefit from the higher revenues of the richer. This principle is incorporated in the cost-sharing agreements which exist between the provinces and the federal government. Probably the most significant benefit to accrue from these

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arrangements has been the acquisition of control by the provincial governments of the licensing of virtually all health institution construction. This eliminates the need for the development of "certificate-of-need legislation" which is confronting many of the states in your country.

A great deal of the history of prepaid medical and hospital insurance plans originated in the Province of Saskatchewan, a very large western province totaling 220,000 square miles of land and 31,500 square miles of inland water. It has a small population, which has remained reasonably static over the past number of years: approximately one million persons, or four persons per square mile. Economically the province depends to a large extent on grain crops, principally wheat, although lately the oil industry and potash mining have assumed increasing importance. In addition, it probably has a rich source of minerals located in the northern part, as yet only moderately developed.

During the depression of the 1930s Saskatchewan probably was the hardest hit area in Canada; to this day scars remain. As a result, people have learned to depend on one another more than in most places, and the cooperative movement has developed extensively. The province was the first to launch tax-supported hospital insurance to maintain medicine in isolated areas. It also started free ambulance service by air, and it was the first province to set up, in 1947, compulsory hospital insurance for all residents. It was also the first in Canada to set up a compulsory medical care insurance program in 1962.

The size of the province, combined with its sparse population, has resulted in obvious difficulties of transportation, particularly during the long and severe winters, and has produced a development of small hospitals which is almost unique.

There are about 140 general hospitals in the Province of Saskatchewan. Of these 96 have less than 25 beds, 22 have between 25 and 49, 16 between 50 and 99, and only 10 more than 100 beds. Of these there are only five with more than 400 beds.

It was natural that Saskatchewan, confronted by many problems of transportation and possessing a multiplicity of small hospitals, should become the first area for the development of formal regional hospital councils. The financing of this type of regional integration and internal regional cooperation was considered a legitimate operating cost of the participating hospitals and was met from governmental sources.

The first of the regional hospital councils was established shortly

after I became director of hospital administration for the Province in 1955. It was set up under the guidance of Dr. Milton Roemer and Mr. Phil Rickard, who was the first executive director.

Basically the first council acted in a consulting capacity and provided more sophisticated accounting services, dietary service, radiology, pathology, medical records, and social service for a group of 13 small hospitals. The formation of the first Regional Council in the southwestern area of Saskatchewan, in the city of Swift Current, was followed by the development of four other similar councils in other parts of the province. However, these regional councils never assumed a planning role, and although they made a great contribution to the improvement of standards of caring for patients, they were too limited in geographical scope and too restricted on a basis of financial operations, particularly in their lack of executive authority. Thus to a large extent they failed to evolve into an effective regional planning body, as we had hoped.

The pattern established in Saskatchewan was followed to a greater or lesser degree, although mainly on a voluntary "interest-group" basis, in other parts of the country.

In 1967 the Province of British Columbia, located on the Pacific Coast of Canada and west of the Rockies, established, by legislation, regional hospital districts. The intention of the government of British Columbia was to establish a grass-roots authority over defined regional hospital districts, and to assign them considerable authority and funds, particularly in the area of planning and constructing hospitals. The system of financing the operations of hospitals was retained centrally. This was a significant development, as it was the first time in Canada that authority was delegated to regional boards in the area of planning and construction. Despite initial nervousness and suspicion, especially on the part of local hospital administrators and boards, regional councils have become a part of the health care system in British Columbia and now enjoy a considerable degree of acceptance. They have been successful mainly because of the delegation of some financial authority to them. In time, therefore, this system should go a long way toward eliminating the duplication of facilities and in ensuring effective planning, with the strong possibility in the future of evolving a coordinated system of hospitals for acute care, for chronic care, and for extended care within the defined region. The acceptance of the regional concept has grown,

to a large extent because of the continued recognition of the individual hospitals and their boards as autonomous units, at least in the operation of their particular facilities.

At present there are other developments of interest in other parts of Canada. In the Province of Ontario, where I am presently located, a number of regional hospital councils have been formed. Probably the most successful of the voluntary groupings of hospitals and health agencies, on an interest basis, has been in the Hamilton area, which has developed a health council (formerly a hospital council) covering the city of Hamilton and several surrounding municipalities.

My own organization, the Metropolitan Toronto Hospital Planning Council, was the first council in Ontario to be established by ministerial order. For many years, prior to the establishment of this Planning Council, a voluntary interest-group organization covered the same metropolitan area and was named the Hospital Council of Metropolitan Toronto. This latter council contributed greatly to the development in Toronto of two regional laundries, a group-purchasing program and, to some extent, to the development of the In-Common or Regional Laboratory. A significant development in the relation of our Planning Council with the original voluntary organization, has been a trial merger which started on the first of January of this year. The Planning Council provides secretarial and consulting help, and shares office space. It is perhaps too early to report on this development, although I am optimistic that, through our present arrangement with the voluntary council, we shall establish a better line of communication with all the hospitals of the metropolitan Toronto area and the men who direct them. Certainly the principles of shared services and cooperation to avoid duplication appear to be well established and will undoubtedly become a very fruitful avenue for future activity.

Historically, hospital care in the metropolitan Toronto area was provided, to a major extent, by a close grouping of teaching hospitals, all located near the core of the city of Toronto. The tremendous increase in population which has occurred in the suburban districts, coupled with the relative stability of the city core population, has resulted in a situation of imbalance in which there is a surplus of hospital beds in the city core and a deficit of beds in the growing suburbs. However, with the development of the Hospital Insurance Plan, a number of hospitals were projected and built in the suburban areas. Almost with-

out exception, all of the teaching hospitals of the University of Toronto are located within a one-mile radius of the university in the downtown core. This has led, of course, to the concentration of highly sophisticated medical and surgical facilities virtually within a stone's throw of one another. Subsequently the Planning Council initiated "role studies" of the districts and, to date, of the five districts involved in the Metropolitan Planning Council area, studies of three are complete. Independent consultants have done one of the studies, and our own staff has done the other two. In addition, another study by an independent firm of consultants, commissioned by government agencies, is examining the role of the teaching hospitals.

These "role studies" consist of detailed reviews of the operation and function of the various districts and their institutions. The studies have been quite involved, and we now have at our disposal a large array of information concerning geographic and age distribution, of population, transportation facilities, interinstitutional relations, location of physicians' offices, and other salient features, which are permitting a much more scientific approach to planning.

We have many contacts with other planning bodies which have given us access to a great fund of information—at no cost. These contacts have been invaluable in another way: they have enabled us to broaden our thinking considerably and to recognize that a number of important points must be taken into consideration. These are:

- 1) The planning of hospitals is not sufficient in itself. The planning must be integrated with the development of a progressive system of caring for patients through the development of home care, primary physician contact resources, nursing homes, homes for the aged, chronic hospitals, rehabilitation centers, and hospitals for acute care.

- 2) The development of an integrated hospital and a system for the delivery of medical care is a highly complex process which will take many years to evolve into a scientific system.

The problems to be faced in the future, and I think we share them with yourselves, are as follows:

- 1) The medical profession is a very loose term for the great variety of highly intelligent individuals who are essentially traditional in their approach, who jealously guard their individualism, and who have a natural suspicion of government. Their guidance, leadership, and participation is essential for success.

2) The history of the development of hospitals is similar in both countries. The institutions have developed independently, community by community, circumstance by circumstance, essentially without outside supervision or control. The concept of regionalization presupposes an appreciable degree of coordination and cooperation between communities and between boards of hospitals and other health centers. It requires a degree of surrender of self-interest to an allegiance to a broader vision. As Dr. Rufus Rorem reminds us, "Coordination needs to be a point of view as well as an administrative structure."

I have spent much time in discussing regionalization. To report on mergers of hospitals in Canada will take only a few moments since the experience has not been extensive. To a considerable extent the mergers which have occurred or are occurring at present have been due to the desire of the Roman Catholic orders to withdraw from the responsibilities of ownership of major institutions. This situation led to the merger of my former hospital, the Holy Cross Hospital of Calgary, with the Rockyview Hospital, under a municipal board. Although the merger arrangement was completed over a year ago, difficulties are still being faced by the board in the integration of the medical staffs of both hospitals. However, the hospitals have been successful in making substantial advances in centralizing financing, purchasing, personnel activity, and the School of Nursing.

In Saskatchewan it has recently been reported that the Grey Nuns Hospital of Regina has passed into provincial ownership. As yet no conclusions have been made concerning the effectiveness of the change in ownership, but the development is being watched with keen interest.

On the other hand, the Province of Manitoba has recently *ordered* the merger of the Winnipeg General Hospital, the Manitoba Children's Hospital, the Rehabilitation Institute, the Cancer Foundation, and the Psychiatric Clinic into a constellation of institutions under one board. Legislation is scheduled for the next session of the Manitoba legislature to accomplish this merger. This was not through the desire of the participants, and a substantial reaction is developing against the loss of autonomy by some of the individual institutions involved.

There are actually many instances of shared services in Canada. However, they exist largely on a patchwork basis, and do not represent a developed pattern of cooperative arrangements. Regional laundry services exist in Kitchener, Waterloo County, and in Toronto, Ont., as

well as at the Winnipeg General Hospital in Manitoba. There has been a provincial pathology service established for many years in Manitoba, serving mainly rural hospitals and public health needs. There are other examples throughout the country where pathology services, such as tissue and chemistry, are established on shared and cooperative bases. For example, the Provincial Laboratory in Regina services, to a large extent, the bacteriological, virological, and biochemical demands of the province from a central location.

The development of joint purchasing, established by the Hospital Council of metropolitan Toronto, through a corporation known as Hospital Purchasing Inc., has effected a savings of a million dollars over the past three years. There are many instances of group purchasing of drugs in different parts of the country. And regional councils in Saskatchewan continue to offer shared services in social work and physiotherapy. Thus we have a Joseph's coat of arrangements!

Time has not permitted me to discuss the important recent developments in the Province of Quebec. It is still in its very early stages, but legislation has now been passed which will enable the government to impose regional systems on the hospitals of that province. Reactions, particularly from the professional groups, have been intense, and it would be invidious to make any further statements on this particular development at this time.

Essentially governments pay lip service to the concept of regionalization, areawide planning, and decentralization. Individual hospital board members and administrators contribute an equal or greater volume of theoretical acquiescence. We are thus faced with the basic problem: governments are reluctant to delegate authority to units at the grass-roots level, and the individual physician, hospital board member, and administrator agree *completely* with regionalization, provided it is for someone else.